State of New Hampshire Insurance Departmetn
56 Old Suncook Road
Concord, New Hampshire 03301-7317

Paula T. Rogers
Commissioner

BULLETIN
Docket No.: INS NO. 00-017-AB

DATE: September 1, 2000

TO: All New Hampshire Licensed Health Insurance Companies, Health Maintenance Organizations and Fraternal Benefit Societies

FROM: Paula T. Rogers
Insurance Commissioner

RE: External Review

This spring, the New Hampshire legislature passed HB 640 (Chapter 18, Laws of 2000) creating an independent external consumer appeal process to review adverse utilization review determinations made by managed care insurers. The law goes into effect September 3, 2000. The law applies to all managed care insurers doing business in the state who provide or perform utilization review, including any insurer that makes an adverse determination concerning a covered person. "Managed care insurer," in this context, means any health insurer that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the insurer. "Utilization review," in this context, means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. "Adverse determination," in this context, means a determination by a health carrier or its designee utilization review entity: (1) concerning a requested admission, availability of care, continued stay or other health care service, supply or drug that is a covered benefit under the terms of the covered person's health benefit plan or that could be a covered benefit under some circumstances, (2) in which the health carrier or its designee utilization review entity finds that, based upon the information provided, the requested service, supply or drug does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and (3) in which the requested service, supply or drug, or payment for such, is therefore denied, reduced, or terminated. If you are a managed care insurer that conducts utilization review, or if you make adverse determinations concerning covered persons, as defined above, then the new law applies to you effective September

3, 2000.

The Insurance Department has certified a number of Independent Review Organizations to conduct the reviews and has filed a proposed interim rule regarding external review that is expected to become effective later this month. The proposed interim rule is posted on the Department's web site. The main address for the Department's web site is http://webster.state.nh.us/insurance/.

Notice to Covered Persons of Their Right to External Review

It is important to note that the new law imposes specific obligations on health carriers regarding notice to members of their right to external review. If carriers follow the notice requirements of Section 2703.04 of the proposed interim rule, the Department will consider this sufficient to show compliance with the notice provisions of the new law. Section 2703.04 of the proposed interim rule would require carriers to provide covered persons the Department's *Managed Care Consumer Guide to External Appeal* and *Request for Independent External Appeal of a Health Care Decision* in specific circumstances. *The Managed Care Consumer Guide to External Appeal* and the *Request for Independent External Appeal of a Health Care Decision* are set out in Appendix A and Appendix B of the proposed interim rule. This section, at Ins 2703.04 (b) – (d), also would require carriers to provide a specific notice to covered persons when their right to external review has been triggered.

Because covered persons who have received final denials on internal appeals within 180 days prior to September 3, 2000 could be eligible to use the independent external review process, health carriers should send, as soon as possible, the Department's *Managed Care Consumer Guide to External Appeal* and *Request for Independent External Appeal of a Health Care Decision* together with the following notice to all such persons. The bolded items should be set out in at least 16 point type, and the remainder of the text in at least 12 point type.

"NOTICE OF RIGHT TO AN EXTERNAL APPEAL
OF YOUR HEALTH INSURER'S DECISION

This spring, the New Hampshire legislature passed a law creating an independent external consumer appeal process for persons who are covered by managed care health insurers. The law went into effect September 3, 2000. Because you completed our internal appeal process within 180 days prior to September 3, 2000, you may now have a legal right under the new law to have our decision reviewed by an organization that is independent and neutral. This process is called Independent External Review and is overseen by the New Hampshire Insurance Department. There is no cost to you for an external appeal.

YOU MUST ASK FOR THIS REVIEW NO LATER THAN 180 DAYS AFTER THE DATE OF OUR FINAL INTERNAL APPEAL DECISION.

To request an independent external review, consult the enclosed Managed Care Consumer Guide to External Appeal, fill out the enclosed Request for Independent External Appeal of a Health Care Decision, attach all supporting documentation, and mail or deliver it to the New Hampshire Insurance Department at:

Independent External Review
New Hampshire Insurance Department
56 Old Suncook Road
Concord, NH 03301-7317

If your medical condition is such that waiting for the standard external review process to be completed would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you may be eligible for expedited external review. Consult the Managed Care Consumer Guide to External Appeal for details on how to request that your appeal be expedited.

If you have any questions about the external review process, please call the New Hampshire Insurance Department at 1-800-852-3416 and ask to speak to a consumer assistant."

Information to be Sent to the Department

The Department must have a current list of names and contact information for informed health insurer personnel who will be the point of contact for independent external review requests and appeals. Please note that in expedited appeals these contact persons must be prepared to immediately access, retrieve and deliver medical records and other information from internal appeals files to the Department. The Department must, at all times, have on file accurate contact information for insurer personnel who can respond immediately. It is the responsibility of the insurer to keep this list up to date at all times. Please make all necessary arrangements and mail or fax this contact information to the following address or phone number as soon as possible, but no later than October 1, 2000.

Independent External Review
New Hampshire Insurance Department
56 Old Suncook Road
Concord, NH 03301-7317

Fax: 603-271-1406

Members Who Are Undergoing Expedited Review in the Health Carrier's Internal Appeal Process

Because the time frame for conducting expedited external reviews is short (72 hours), the Department needs to be notified in advance by the health carrier when a

covered person has requested second-level expedited internal grievance review. Please note that the proposed interim rule, at Ins 2703.06, would require that when a covered person requests second-level expedited internal grievance review the health carrier must immediately notify the Department of the existence of the request and of the expected time frame for making a decision on that request.

The Department's Initial Approach to Enforcement

Pending the effective date of an interim rule, the Department will consider health carriers to be in compliance with the new law if they are complying with all of the provisions of the proposed interim rule. Of course, certain provisions of the proposed interim rule and of this Bulletin will require some time to implement—such as the requirement to add certain specific materials to the policy, certificate, membership booklet, or other evidence of coverage provided to covered persons. So long as a health carrier is taking prompt, good faith action to bring itself into compliance with the requirements contained in the proposed interim rule and in this Bulletin, the Department will not attempt to sanction the carrier.